DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
DIVISION OF LONG-TERM CARE

INFORMED CONSENT FOR PARTICIPATION IN VIRGINIA'S MONEY FOLLOWS THE PERSON PROGRAM

Completion of this form and participation in Virginia's Money Follows the Person Program (MFP) is voluntary. I am not required to complete this form or participate in this program. If I choose not to complete this form, I am ineligible for participation in the MFP. Whatever decision I make, I may still transition to the community and I will continue to be eligible for Medicaid and for home and community-based services.

Participant Name: _____
Current Institutional Residence: _____
Medicaid: ☐☐☐-☐☐☐☐☐☐-☐☐-☐

I, _____, have been informed, allowed to ask questions, and understand that:

☐ My participation in the MFP Project is voluntary.

☐ The MFP is sponsored by the federal Centers for Medicare and Medicaid (CMS) and support-states to strengthen their long-term support systems, transition individuals from institutions, and improve the long-term care systems.

☐ CMS gave a demonstration award to the Virginia Department of Medical Assistance Services (DMAS) to implement the MFP in Virginia.

☐ CMS has contracted with Mathematica Policy Research to evaluate the MFP Project nationwide. With my permission, if I choose, certain information about me will be shared with CMS and with Mathematica Policy Research in order to meet the legal requirements to evaluate the MFP.

☐ If I decide not to participate in the MFP Project, I will continue to be eligible for Medicaid home and community-based services, or Program of All Inclusive Care for the Elderly (PACE), if I reside in an area that provides the PACE program.

☐ Upon completion of my one year enrollment in the MFP, I will automatically continue to be enrolled in a Medicaid Waiver or PACE program as long as I continue to meet criteria for the Medicaid Waiver or PACE eligibility.

BENEFITS OF THE MFP

Potential benefits from my participation in the MFP Project include the following:

☐ I have been made aware of services under the MFP Project that will assist me to transition from the institution to live successfully in the community. In addition to home and community-based waiver or PACE services, I understand the following services are available only to people who participate in the MFP:

- A 24 hour, seven day per week back-up system to assist me with obtaining essential services;
- Additional environmental (home) modification funding if I need more than $5,000 to make necessary changes to my home or apartment; and
- If needed, payment of my rent from the time I sign the lease until the time I can move into my home or apartment once the environmental (home) modifications are complete (up to 90 days) may be paid for by Virginia Housing and Community Development.

☐ At the end of one year, if I continue to meet Medicaid eligibility requirements then I will continue to receive the same WAIVER services through the Medicaid home and community-based program.

☐ When I participate in the MFP I will have the opportunity to complete the Quality of Life Surveys. My answers to the questions on this survey will help State and Federal officials to evaluate the success of Virginia's MFP and make improvements to community supports to allow more persons to move back into their communities.

POTENTIAL RISKS

☐ There is a chance (risk) that my confidential information could be released to an organization that is not authorized to see it. The risk of this unauthorized release is very low because procedures are in place to protect my information and limit its release to other parties (as described below.) This risk exists even if I do not participate in the MFP.

PARTICIPATION IN EVALUATING THE MFP PROJECT

☐ I understand that information about my participation in the MFP Project will be provided to CMS and to Mathematica Policy Research, the evaluation contractor hired by CMS.

☐ I may be asked to voluntarily respond to surveys, take part in visits to my home or otherwise communicate with DMAS staff or its designated agent for the MFP... I know that I may not be dropped from the program if I choose not to respond to these surveys, participate in home visits or otherwise communicate with DMAS staff or its designated agent about the surveys.

☐ I have been provided the opportunity to read material describing the evaluation of the MFP which included the basic goals of the evaluation, the types of data that will be collected, how the confidentiality of the data is protected, the benefits and risks associated with the evaluation, and who I can contact if I have any questions about the evaluation material.

PRIVACY

☐ I have been informed that the information provided by DMAS to CMS and Mathematica Policy Research is confidential and will be protected under the Health Information Privacy and Portability Act (HIPAA). I know that I may receive a copy of the DMAS HIPAA privacy policies and procedures at my request. .

WITHDRAWAL FROM THE MFP

☐ I know that my participation in the MFP Project is voluntary and if I enroll in the MFP and change my mind and no longer wish to be in MFP that, I may withdraw at any time by completing a withdrawal form. I can get the form from my Case Manager, Transition Coordinator or staff from DMAS.

COMPLAINTS

☐ **About my health and safety**: I understand that if I have a complaint or concern that affects my health, safety or well-being and is an urgent situation, I can call:

- 9-1-1 for life-threatening emergencies
- 2-1-1 for emergency back up of essential services
- 1-888-832-3835 to report allegations of adult abuse, neglect or exploitation
- 1-800-552-7096 to report allegations of child abuse or neglect.

☐ I understand that my provider is required by law to report critical incidents (suspected abuse, neglect and exploitation) to appropriate entities, including licensing authorities.

About my participation in the MFP

☐ I understand that if I have any concerns about my participation in the MFP or if I would like to receive e-mail updates I can contact DMAS staff at:

Department of Medical Assistance Services
Money Follows the Person Program
600 East Broad Street, 10th Floor
Richmond, Virginia 23219
Phone: (804) 225-4222
Fax: (804) 371-4986
mfp@dmas.virginia.gov

☐ I understand that I have certain rights to file a grievance or appeal a decision as an individual using Medicaid waiver services. My Case Manager or Transition Coordinator has provided me with information regarding my rights as an individual using Medicaid waiver services and with information regarding the process to file a grievance or appeal.

CONSENT

☐ I have been given a brochure that explains to me my rights and responsibilities under the MFP. I understand that I will be given a signed copy of this consent form to keep. If I have questions about the MFP Project that cannot be answered by the brochure, I can talk to my Case Manager, Transition Coordinator, or call DMAS at (804) 225-4222.

By signing this Informed Consent, I am agreeing to participate in the MFP Project and to accept all conditions for participation.

SIGNATURE – Participant Date Signed

Address (Street, City)

Address (State, Zip Code)

Telephone Number (including area code)

SIGNATURE – Witness (if applicable) Date Signed
A witness may indicate that a participant agreed by making a mark above.

SIGNATURE – Legal Guardian (if applicable) Date Signed

Address (Street, City)

Address (State, Zip Code)

Telephone Number (including area code)

CASE MANAGER OR TRANSITION COORDINATOR ACKNOWLEDGEMENT

I have provided a copy of informed consent materials to _____ (name), and I offered to address any questions or provide information upon request.

SIGNATURE – Case Manager or Transition Coordinator Date Signed

Agency Name

Telephone Number (including area code)

OPTION TO VOLUNTARILY DECLINE PARTICIPATION

☐ I was offered the opportunity to participate in the MFP Project and have chosen to decline. I understand that this will not affect my eligibility for Medicaid or home and community-based services.

SIGNATURE – Participant Date Signed

Address (Street, City)

Address (State, Zip Code)

Telephone Number (including area code)

SIGNATURE – Witness (if applicable) Date Signed
A witness may indicate that a participant agreed by making a mark above.

SIGNATURE – Legal Guardian (if applicable) Date Signed

Address (Street, City)

Address (State, Zip Code)

Telephone Number (including area code)

DMAS must receive copies of all "OPTION TO VOLUNTARILY DECLINE PARTICIPATION" forms, copies should be forwarded to DMAS at:

Department of Medical Assistance Services
Long-Term Care Division - MFP
600 East Broad Street, 10th Floor
Richmond, Virginia 23219
Phone: (804) 225-4222
Fax: (804) 371-4986

INFORMED CONSENT INSTRUCTIONS

1) Enter Participant's Full Legal Name.
2) Enter the name of the Participant's Current Institutional Residence.
    i. Example: ABC Nursing Facility
3) Enter the Participant's 12-digit Medicaid Number
4) Enter the Participant's Name in blank provided.
5) Check each box as the information is reviewed with the participant.
6) Complete the Consent Section with the Participant's Information.
7) If the Participant is unable to sign, but can make their legal mark, then a witness needs to sign and date that they verified Participant's legal mark.
8) Complete the Consent Section with the Legal Guardian's Information, if applicable.
9) Complete the Case Manager/Transition Coordinator Section with the appropriate information.
10) If applicable, complete the Option to Formally Decline Participation Section. This section is only completed if the Participant is opting ***NOT*** to participate in the MFP program.
11) Original forms must be maintained in the Participant's MFP record by the Transition Coordinator or Case Manager for a period of not less than five years from the date of service.